Allergen Immunotherapy [Refer to WAC 388-531-0950(10)]

Payment for antigen/antigen preparation (CPT codes 95145-95149, 95165, and 95170) is per dose.

Service Provided	What should I bill?
Injection and antigen/antigen preparation for allergen immunotherapy	✓ One injection (CPT code 95115 or 95117); ***and*** ✓ One antigen/antigen preparation (CPT codes 95145-95149, 95165 or 95170).
Antigen/antigen preparation for stinging/biting insects	✓ CPT codes 95145-95149 and 95170
All other antigen/antigen preparation services (e.g., dust, pollens)	✓ CPT code 95144 for single dose vials; ***or*** ✓ CPT code 95165 for multiple dose vials.
Allergist prepared the extract to be injected by another physician	✓ CPT code 95144
Allergists who billed the complete services (CPT codes 95120-95134) and used treatment boards	✓ One antigen/antigen preparation (CPT 95145-95149, 95165, and 95170); and ✓ One injection (CPT code 95115 or 95117).
Physician injects one dose of a multiple dose vial	✓ Bill for the total number of doses in the vial and an injection code
Physician or another physician injects the remaining doses at subsequent times	✓ Bill only the injection service

For an allergist billing both an injection and either CPT code 95144 or 95165, payment is the injection fee plus the fee of CPT code 95165, regardless of whether CPT code 95144 or 95165 is billed. The allergist may bill an Evaluation and Management (E&M) procedure code for conditions not related to allergen immunotherapy.

Psychiatric Services [Refer to WAC 388-531-1400]

Note: These billing instructions are not for use by Psychologists. Refer to the current Department/MPA *Psychologist Billing Instructions* for a description of the Psychology program. To view the billing instructions online, go to http://hrsa.dshs.wa.gov/download/BI.html.

General Guidelines

- The Department pays a maximum of one psychiatric service procedure code per client, per day.

- Psychiatrists must bill using one procedure code for the total time spent on direct client care during each visit. Making inpatient rounds is considered direct client care and includes any one of the following:

  - ✓ Individual psychotherapy (CPT codes 90804-90809, 90810-90815*, 90816-90822, and 90823-90829*);
  - ✓ Family psychotherapy (CPT code 90847);
  - ✓ Group psychotherapy (CPT codes 90853 and 90857);
  - ✓ Electroconvulsive therapy (CPT codes 90870); or
  - ✓ Pharmacological management (CPT code 90862).

- When performing both psychotherapy services and an E&M service during the same visit, use the appropriate psychiatric procedure code that includes the E&M services [e.g., CPT code 90805 (outpatient psychotherapy with E&M) or CPT code 90817 (inpatient psychotherapy with E&M)].

- A psychiatrist may not bill for a medical physical examination in the hospital (CPT codes 99221-99233) in addition to a psychiatric diagnostic or evaluation interview examination (CPT code 90801 for adults or 90802 for children).

- The Department pays psychiatrists for the CPT codes listed in the following tables only when billed in combination with the diagnoses listed in the table. **For each date of service billed, the diagnosis on the detail line must indicate the specific reason for the visit.**

- Psychiatric sleep therapy is not covered.

***Interactive psychotherapy is limited to clients 20 years of age and younger.**

Covered Services for Psychiatrists Using ICD-9-CM Diagnosis Codes 290.0-319

Inpatient Hospital

Covered Procedure	CPT Codes
Initial Hospital Care	99221-99223
Subsequent Hospital Care	99231-99233
Inpatient Consultation	99251-99255
Inpatient Psychotherapy	90816-90822, 90823-90829*

*Codes 90823-90829 are limited to clients 20 years of age and younger.

Outpatient Hospital

Covered Procedure	CPT Codes
Observation	99234-99239
Psychotherapy	90804-90815
Consultation	99241-99245

Office

Covered Procedure	CPT Codes
Consultation	99241-99245
Psychotherapy	90804-90815

Other Psychiatric Services

Covered Procedure	CPT Codes
Psychiatric Diagnostic Interview	90801, 90802
Other Psychotherapy	90845, 90847, 90853
Other Psychiatric Services	90862-90870, 90899
Case Management Service • Team Conferences • Telephone Calls	 99367 99441-99443

The Department does not pay for the following psychotherapy codes when billed with office E&M codes:

90805	90807	90809	90811	90813	90815	90817
90819	90822	90824	90827	90829		

The following procedure codes are limited to clients 20 years of age and younger: 90823-90829, 90810-90815, and 90802.

Noncovered Services for Psychiatrists Using ICD-9-CM Diagnosis Codes 290.0-319

The Department does not cover the following services for psychiatrists using ICD-9-CM diagnosis codes 290.0-319:

- Office visits (99201-99215);
- Emergency department visits (99281-99288);
- Nursing facility services (99304-99318);
- Domiciliary home or custodial care services (99324-99340);
- Home services (99341-99359); and
- Stand-by services (99360).

Limitations for Inpatient Psychiatric Services

- Admissions for acute, community psychiatric inpatient care require PA from the designated Division of Behavioral Health and Recovery (DBHR) Designees which are referred to as the Regional Support Networks (RSNs). The hospital obtains the prior authorization. Please see the list of RSNs at the Division of Mental Health's web site: http://www1.dshs.wa.gov/mentalhealth/rsndirectory.shtml.

- The Department does not cover physician services for clients admitted for voluntary psychiatric admissions on the psychiatric indigent inpatient PII program who are covered under the "MIP-EMER No out-of-state care" Benefit Service Package.

- Psychiatric diagnostic interview examinations (CPT codes 90801 and 90802) are limited to one in a calendar year per provider. PA is required if a second examination is needed because of a change in a client's condition or if they have a change in legal status (i.e., voluntary to involuntary or involuntary to voluntary). CPT code 90802 is limited to those clients who are 20 years of age and younger.

Limitations for Outpatient Psychiatric Services

Outpatient psychiatric services are not allowed for clients on the General Assistance Unemployable (GAU) program, except for medication adjustment (CPT code 90862).

Expanded Mental Health Services for Children

F**or clients 18 year of age and younger the Department will:**

- Increase the number of hours allowed for psychotherapy up to a maximum of 20 hours per calendar year; and

- Allow more providers to perform these mental health services.

Who is eligible for the expanded benefits?

Due to new legislation intended to improve access to mental health services for children who do not meet the Regional Support Network (RSN) Access to Care Standards, the Department is expanding mental health services for clients 18 years of age and younger who are eligible through one of the following Benefit Service Packages:

- Categorically Needy Program (CNP);
- Children's Health Program (CNP);
- State Children's Health Insurance Program (SCHIP); or
- Limited Casualty – Medically Needy Program (LCP-MNP).

Clients enrolled in Healthy Options plans will have this new benefit. Please contact the client's plan for more information. (Refer to RCW 74.09.521.)

> **Note:** Please note that this benefit is for children who do not meet the RSN's access to care standards. If it is medically necessary, therapists need to transition care of the child to the RSN, as appropriate to the child's condition.

How many hours will the Department pay for?

The Department will pay providers one psychiatric service per day, up to a maximum of 20 hours, which includes the evaluation, per eligible client, per calendar year for the expanded services listed on page E.9. This may include some hours delivered by one provider and other hours delivered by another provider.

How do I know how many hours of a client's benefit have been billed for?

It is the provider's responsibility not to provide services beyond the client's maximum benefit.

Contact the Department by calling **1-800-562-3022 (TTY): 1-800-848-5429** to find out how many hours of a client's benefit have already been billed. The Department will not pay for services exceeding the 20-hour maximum per calendar year limitation unless the provider has requested and obtained a limitation extension from the Department.

What will I do if the client has exhausted the maximum benefit?

Fee-For-Service:

For any additional fee-for service outpatient mental health services needed for clients who have exhausted their 20 hour per calendar year benefit limit, the provider must request and obtain a limitation extension from the Department following the requirements found in WAC 388-501-0169 including:

- Justification of medical necessity;
- Description of services provided and outcomes obtained in treatment to date; and
- Expected outcome of extended services.

> **Note:** For the Department to authorize payment, a completed Basic Information Form, DSHS 13-756, must be faxed to the Department (see *Important Contacts* section).

Healthy Options Managed Care:

For any additional Healthy Options Managed Care outpatient mental health services needed for clients who have exhausted their 20 hour per calendar year benefit limit, the provider must request and obtain a limitation extension from the client's MCO following the MCO identified requirements and process.

> For more information, including verification of the number of hours already paid by the Department for a client, contact the Department (see *Important Contacts* section).

Who may provide the expanded services?

Effective for dates of service on and after July 1, 2008 the following list of mental health professionals, as defined in **RCW 71.34.020** and licensed by the Department of Health, may provide and bill the Department fee-for-service for the expanded mental health services to children:

- **Psychiatrist:** Licensed Psychiatrist;
- **Psychologist:** Licensed Psychologist;
- **Psychiatric Nurse:** Licensed Advanced Registered Nurse Practitioner;
- **Social Worker:** Licensed Independent Clinical Social Worker or Advanced Social Worker;
- **Marriage and Family Therapist:** Licensed Marriage and Family Therapist; and
- **Mental Health Professionals:** Licensed Mental Health Counselor.

> **Note:** Mental health professionals must meet the provider requirements listed in this memo to be eligible to provide expanded services.

How are children's mental health services administered?

Children's outpatient mental health services are available through:

- Regional Support Networks (RSNs) which are under contract with the Department's Mental Health Division for individuals whose condition meets the RSN Access to Care Standards,
- Managed Care Organizations (MCOs) which are under contract with the Department's Healthy Options program for individuals enrolled with an MCO whose condition does not meet the RSN Access to Care Standards, or
- Professionals with individual Core Provider Agreements who will accept payment on a Fee-For-Service (FFS) basis for individuals not enrolled with an MCO whose condition does not meet the RSN access to care standards.

What services do the Regional Support Networks cover?

RSN Crisis Services:

Crisis mental health services are provided upon request, 24-hours a day, 7 days a week and are available to anyone who needs them regardless of ability to pay. All RSN's publish a toll free crisis number in local phone books.

To find numbers for crisis intervention services, visit the Department on-line at:
http://www1.dshs.wa.gov/Mentalhealth/crisis.shtml

RSN Community Psychiatric Inpatient Services:
RSNs authorize and pay for all medically necessary community psychiatric inpatient services (WAC 388-550-2600). To refer a client for community psychiatric inpatient services, contact your local RSN.

To find the appropriate RSN and contact information, visit the Department on-line at:
http://www1.dshs.wa.gov/Mentalhealth/rsnmap.shtml

RSN Access to Care Standards:

In addition to providing crisis intervention services and community inpatient services, the RSNs also manage the public mental health services that are delivered by Mental Health Division (MHD) licensed and RSN contracted community mental health agencies to individuals who are Medicaid or SCHIP eligible who also meet the Access to Care Standards (ACS). As resources allow, some medically necessary services may be provided to indigent clients who meet the ACS, however this is determined at the local level. ACS are established by the Department and are approved by the Centers for Medicare and Medicaid Services (CMS).

> **Note:** If you are treating or evaluating a child or youth who appears to meet the ACS, contact the local RSN to make a referral for an intake evaluation.

To meet the ACS for children and youth, the following five conditions must be true:

1. The child or youth is determined to have a mental illness that is listed as a covered diagnosis found in the ACS under "Covered Childhood Disorders",

2. The impaired level of functioning and corresponding need(s) identified must be as a result of mental illness,

3. The intervention is deemed reasonably necessary to improve, stabilize or prevent deterioration of functioning resulting from the presence of a mental illness,

4. The child or youth is expected to benefit from the intervention, and

5. The unmet need(s) of the child or youth cannot be appropriately met by any other formal or informal system or support.

To learn more about the ACS, visit the Department on-line at:
http://www1.dshs.wa.gov/Mentalhealth/publications.shtml

Services Provided by Psychiatrists

For Clients 18 years of age and Younger

Psychiatrists may bill one psychiatric service per day, up to a maximum of 20 hours, which includes the evaluation, per client, per calendar year for clients 18 years and younger using the following procedure codes:

CPT Procedure Code	ICD-9 CM Diagnosis Code	Limitations
90801*	Must be billed with these diagnosis codes: 290.0-319.	One psychiatric diagnostic interview exam allowed per client, per provider, per calendar year.
90802*		One psychiatric diagnostic interview exam allowed per client, per provider, per calendar year.
90804		
90805		
90806		
90807		
90808		
90809		
90810		
90811		
90812		
90813		
90814		
90815		
90845		
90847		
90853		
90857		
90865		
90870		
90899		

Note: When a client is seen for a psychiatric service as listed above, and medication management is necessary, a psychiatric ARNP or a physician may bill medication management (CPT code 90862) on the same day. Psychiatrists can also bill other procedures listed on page E.3 which are not subject to the 20-hour visit limitation.

*The Department pays for only one psychiatric diagnostic interview exam (90801 or 90802) per client, per provider, per calendar year. This exam is included in the 20–hour-per-calendar-year maximum unless a significant change in the client's circumstances requires an additional exam and the provider obtains prior authorization for the additional exam.

Note: Pharmacological management is not subject to the 12-visit limitation.

For Clients 19 years of age and Older

- The Department limits outpatient psychotherapy and electroconvulsive therapy in any combination for clients 19 years of age and older to one hour per day, per client, up to a total of 12 hours per calendar year. This includes family or group psychotherapy. The following codes are included in the allowed 12 hours:

90804	90805	90806	90807	90808	90809	90810
90811	90812	90813	90814	90815	90845	90847
90853	90857	90865	90870	90899		

Note: Pharmacological management is not subject to the 12-visit limitation.

Services Provided by Psychiatric Advanced Registered Nurse Practitioners (ARNPs)

Provider Requirements

Psychiatric ARNPs may bill the expanded mental health services to children when they have met the following provider requirements:

To provide the services listed in the code tables on the following pages, mental health professionals must:

- Be licensed by DOH and be in good standing without restriction.

- Have a minimum of two years experience in the diagnosis and treatment of children and youth, and their families; at least one year must have been under the supervision of a mental health professional trained in child and family mental health.

Note: A licensed psychiatrist may provide services and bill the Department without meeting this minimum experience requirement.

Enrollment

How do I enroll to provide mental health services to children?

To enroll you must:

- Obtain a National Provider Identifier (NPI) from the federal government;
- Complete a Core Provider Agreement (if you are already an enrolled provider you must send in this additional information to bill for these services);
- Write and sign a letter attesting to your experience in providing mental health services to children, youth and their families as described above (the letter does not need to be notarized); and
- Send all of the above to the Provider Enrollment (see the *Important Contacts* section). **For more information,** contact Provider Enrollment.

Psychiatric ARNPs that meet the requirements listed on page E.10 are approved to bill the expanded mental health services for children (see *Psychiatric ARNP Code Table 1*) and may bill one psychiatric service per day, up to 20 hours, per calendar year, **for clients 18 years of age and younger**. This includes the diagnostic interview exam (90801 or 90802).

These psychiatric ARNPs may also bill the CPT codes in *Psychiatric ARNP Code Table 2* **for clients of any age**.

PSYCHIATRIC ARNP CODE TABLE 1		
CPT Procedure Code	**ICD-9 CM Diagnosis Code**	**Limitations**
90801*	Must be billed with these diagnosis codes: 290.0-319.	One psychiatric diagnostic interview exam allowed per client, per provider, per calendar year.
90802*		One psychiatric diagnostic interview exam allowed per client, per provider, per calendar year.
90804		
90805		
90806		
90807		
90808		
90809		
90810		
90811		
90812		
90813		
90814		
90815		
90847		
90853		
90857		
90899		

Note: When a client is seen for a psychiatric service as listed above, and medication management is necessary, a psychiatric ARNP or a physician may bill medication management (CPT code 90862) on the same day.

*The Department pays for only one psychiatric diagnostic interview exam (90801 or 90802) per client, per provider, per calendar year. This exam is included in the 20–hour limitation unless a significant change in the client's circumstances requires an additional exam and the provider obtains prior authorization.

When a psychiatric ARNP is performing both psychotherapy services and Evaluation & Management (E&M) services during the same visit, use the appropriate psychiatric CPT procedure code that includes the E&M service (e.g., CPT code 90805)

Note: Pharmacological management is not subject to the 12-visit limitation.

Psychiatric ARNPs **who have not applied or do not meet the requirements on page E.10** may bill for the services in *Psychiatric ARNP Code Table 2* only, for clients of any age. When billing, you must use a psychiatric diagnosis code in the range of 290.0-319:

PSYCHIATRIC ARNP CODE TABLE 2	
Covered Procedure	**CPT Codes**
Initial Hospital Care	99221-99223
Subsequent Hospital Care	99231-99233
Observation Hospital	99234-99239
Psychiatric Diagnostic Interview	90801, 90802
Pharmacological Management	90862
Case Management Services • Team Conferences • Telephone Calls	99367 99441-99443

The Department does not pay the same provider for psychiatric procedure codes and E&M procedure codes on the same date of service unless there are two separate visits and the provider bills using modifier 25 to indicate a significant and separately identifiable condition exists and is reflected by the diagnosis.

The Department does not pay psychiatric ARNPs for psychotherapy for adults 21 and over. The Department pays one psychiatric diagnostic interview examination 90801 or 90802 once a calendar year. Office visits 99201 – 99215 cannot be billed for psychotherapy. Pharmacologic management 90862 can be billed when prescribing medication, use and review of medication with no more than minimal medical psychotherapy.

Pharmacological Management (CPT 90862)

Pharmacological management refers to the in-depth management of psychopharmacological agents, which are medications with the potential for serious side effects. It represents a skilled aspect of care for a client who has been determined to have a mental illness. The focus of a pharmacological management visit is the use of medication for relief of the client's signs and symptoms of mental illness. When the client continues to experience signs and symptoms of mental illness that require discussion beyond minimal psychotherapy, the focus of the service is broader and is considered psychotherapy rather than pharmacological management.

Pharmacological management (CPT 90862):

- May be billed when prescribing the medication(s) and when reviewing the effects of the prescribed medication(s), with no more than minimal medical psychotherapy.
- Is intended for use for clients who are being managed primarily by psychotropic medications.
- Must be provided during a face-to-face visit with the client, unless it is part of a qualified telehealth visit.

Documentation Requirements

The medical record must be clear, concise, and complete. A check-off list by itself is not accepted as complete documentation. The treating provider must document in the medical record that pharmacologic management was reasonable and medically necessary. The claim and the medical record must list the diagnosis that most accurately describes the condition that necessitated pharmacological management.

Documentation of medical necessity for pharmacological management must address **all of the following** information in the client's medical record in legible format:

- Date and time.
- Diagnosis – update at least annually.
- Interim medication history.
- Current symptoms and problems, including any physical symptoms.
- Problems, reactions, and side effects, if any, to medications and/or ECT.
- Current mental status exam.
- Any medication modifications.
- The reasons for medication adjustments/changes or continuation.
- Desired therapeutic drug levels, if applicable.
- Current laboratory values, if applicable.
- Anticipated physical and behavioral outcome(s).

Involuntary Treatment Act (ITA)

For persons over the age of 12 (see "Age of Consent" below) who are detained under the provisions of the Involuntary Treatment Act (ITA) as defined by chapters 71.05 and 71.34 RCW, the MHD designee authorizes and pays for services provided to clients who are receiving medical assistance. When the client is in the process of applying for medical assistance, payment by the MHD designee is subject to the eligibility determination.

The MHD designee also authorizes services that are provided to clients detained under ITA law when the client either refuses to apply for, or does not qualify for, any medical assistance program as described. These stays are paid for through the use of state funds.

Unlike the PII program, under ITA, the Department ***does*** cover the ancillary charges for physicians,-transportation (including ambulance), or other costs associated with an involuntary hospital inpatient psychiatric hospitalization.

For all clients involuntarily detained under Chapter 71.34 and 71.05 RCW, physicians may provide psychiatric services under the Involuntary Treatment Act according to the following guidelines:

- Each involuntarily committed person must be examined and evaluated by a licensed physician or psychiatrist within 24 hours of admission or payment will be denied. This evaluation may be used for both treatment purposes and court testimony. Bill admissions through the emergency room using either CPT code 90801 or 90802.

- A day's rounds, along with any one of the following, constitute direct client care: narcosynthesis, brief (up to one hour) individual psychotherapy, multiple/family group therapy, group therapy, or electroconvulsive therapy.

- A copy of the Initial Certification Authorization for Admission to Inpatient Psychiatric Care form, DSHS 13-821, that a hospital completes for prior authorization from the designated RSN must accompany the claim. If the client is admitted longer than 20 days, the physician must include a copy of the Extension Certification Authorization for Continued Inpatient Psychiatric Care form, DSHS 13-822. You may view/download these forms at http://www1.dshs.wa.gov/msa/forms/eforms.html.

- A court may request another physician or psychiatrist evaluation.

- The Department pays for physician and psychiatrist evaluations and consultations to the court regarding the need for continued involuntary psychiatric hospitalization of a client. Documentation of the time required for actual testimony must be maintained in the client's medical record. Only one court testimony is paid per hearing. Bill using the medical testimony code (CPT code 99075) for time spent doing court testimony.

- **Psychologist services** are covered *only* for provision of a psychological evaluation of detained clients. (See the Department's *Psychologist Billing Instructions* for related policy and/or procedure codes). As with all other claims, an authorization form must accompany the claim. Attaching the authorization form serves as verification of the involuntary status.

- **Out-of-state hospitals** must obtain authorization from the appropriate MHD designee for all Medicaid clients. Neither the Department nor the MHD designee pays for inpatient services for non Medicaid clients if provided outside of State of Washington. An exception is for clients who are qualified for the General Assistant – Unemployable (GAU) program. For these clients, the Department and the MHD designee pays for inpatient psychiatric services provided in bordering cities and critical access border hospitals. All claims for admissions to **out-of-state hospitals** are paid as **voluntary** legal status as the Involuntary Treatment Act applies only within the borders of Washington State.

Note: One unit = 10 minutes. A maximum of five units is allowed.

- Additional costs for court testimony are paid from county ITA administrative funds.

EPA Criteria for Neuropsychological Testing (CPT codes 96118 and 96119)

Note: If the client does not meet the EPA criteria listed in this section, the Department requires PA for the testing. In addition, the Department requires providers to request PA for testing that exceeds 15 hours per calendar year.

Services(s)	Neuropsychological testing of adults, age 16 and over, in an outpatient or inpatient setting.
Providers	The Department pays only "qualified" providers for administering neuropsychological testing to eligible Department clients. To be "qualified," providers must be: • Currently licensed in Washington state to practice psychology and/or clinical neuropsychology; and • Either: ✓ Board-certified in clinical neuropsychology by the American Board of Clinical Neuropsychology; or ✓ Have adequate education, training, and experience as defined by having completed **all** of the following: ➢ A doctoral degree in psychology from an accredited university training program; ➢ An internship, or its equivalent, in a clinically relevant area of professional psychology; and ➢ The equivalent of two full-time years of experience and specialized training, at least one of which is at the post-doctoral level, in the study and practice of clinical neuropsychology and related neurosciences. These two years must include supervision by a clinical neuropsychologist.
Billing Codes	96118 and 96119 may be billed with EPA # 870001207 if all the criteria in this section are met.

Neuropsychological Testing (cont.)

Billing and Payment Limits	A qualified provider may bill 96118 alone if he or she administers the test. If a technician administers the test, 96119 must be billed with 96118 to account for the professional interpretation and report of test results. Up to a maximum of 15 hours per calendar year for a combination of CPT 96118 and 96119 are allowed for patients who meet the criteria specified here. **Note:** If the client does not meet the criteria in this section or requires more than 15 hours of testing, the provider must request PA.
Criteria	The following are four groups of criteria that apply in different circumstances. To assist with rehabilitation efforts and manage outcomes in inpatient physical medicine and rehabilitation (PM&R) patients, criteria in Group 1 must be met. For outpatient or non-PM&R inpatient settings, criteria in any one of groups 1-4 must be met. **Group 1** • The patient to be evaluated has, or is suspected to have, an acquired injury to the brain as a result of traumatic brain injury, stroke, multiple sclerosis, aneurysm, anoxia, dementia, neoplasm, or chemotherapy; • The patient is of working or school age (age 16 and older); • The patient was functioning normally (was able to attend school, work competitively, or live independently) prior to the brain disorder; • The patient has potential to return to important areas of role functioning (e.g., work, school, or independent living); **AND** • Testing will be used only in conjunction with functionally based rehabilitation, not "cognitive" rehabilitation.

Neuropsychological Testing (cont.)

Criteria (cont.)	**Group 2** The client is suspected to have a diagnosis of dementia or multiple sclerosis based on one of the following: • Client or family complaints; • A head CT (computed tomography scan); or • A mental status examination or other medical examination. This suspected diagnosis is not confirmed or able to be differentiated from the following: • Normal aging; • Mild concussion; • Depression; or • Focal neurological impairments. A firm diagnosis would change the medical treatment plan, clinical management, or aid important client or family decisions. **Group 3** The client is undergoing brain surgery for epilepsy, a tumor, or Parkinson's disease, and neuropsychological testing may help: • Guide the surgeon in the goal of sparing healthy brain tissue or sites that are critical to some major function such as language; or • Identify poor candidates for neurological surgery due to dementia (e.g., in cases where deep brain stimulation implants are being considered to manage intractable tumors). **Group 4** The client is being considered for surgery (e.g., a lung transplant), and neuropsychological testing may help identify if the client is a poor candidate for general surgery (e.g., in cases where cognitive impairment from chronic hypoxia or other risk factors make it unlikely that the person can accurately follow a rigorous post transplant protocol to prevent organ rejection).

Note: If the client does not meet the criteria in this section, the provider must request prior authorization (PA). Fax the request to MPA at 1-360-586-1471.

Podiatric Services [Refer to WAC 388-531-1300]

- The Department pays podiatrists for:

  - ✓ Those procedure codes and diagnosis codes that are within their scope of practice;

  - ✓ Routine foot care only when a medical condition affecting the legs or feet (such as diabetes or arteriosclerosis obliterans) requires an M.D., D.O., or podiatrist to perform this care.

    Examples of a medical condition include, but are not limited to:

    - ➢ Limitation of ambulation due to mycosis.

    - ➢ Likelihood that absence of treatment will result in significant medical complications.

  - ✓ Those orthotics listed on pages K.6 and K.7. If prior authorization (PA) or expedited prior authorization (EPA) is required, see Section I.

Note: If the description of the orthotic code indicates the code is for a single orthotic or impression casting of one foot, either modifier RT or LT **must** be included on the claim. Providers must use an appropriate procedure code with the word "pair" in the description when billing for fabrications, casting, or impressions of both feet.

  - ✓ An Evaluation and Management (E&M) code and an orthotic on the same day if the E&M service performed has a separately identifiable diagnosis and the provider bills using modifier 25 to indicate a significant and separately identifiable condition exists and is reflected by the diagnosis.

- Medicare does not pay for orthotics and casting. Providers may bill the Department directly for those services without submitting a Medicare denial, unless the client's Services Card indicates *QMB - Medicare only*, in which case the orthotics and casting is not covered by the Department.

- Biomechanical evaluation (the evaluation of the foot that includes various measures and manipulations necessary for the fitting of an orthotic) is included in the orthotic fee.

Limitations

- Local nerve blocks for subregional anatomic areas (such as the ankle and foot) are included in the payment for the surgical procedure and are not paid separately.

- Payment for debridement of nails is limited to a maximum of one treatment in a 60-day period.

- The Department pays podiatrists for covered, diagnostic, radiologic services of the ankle and foot only when the client is examined before the x-ray is ordered.

What is not covered?

- X-rays for soft tissue diagnosis;
- Bilateral x-rays for unilateral condition;
- X-rays in excess of two views;
- X-rays that are ordered before the client is examined;
- X-rays for any part of the body other than the foot or ankle;
- Treatment of flat feet; and
- Treatment of fungal (mycotic) disease.

Radiology Services [Refer to WAC 388-531-1450]

General Limitations on Radiology Services

The following services are not usually considered medically necessary and may be subject to post-pay review:

- X-rays for soft tissue diagnosis;
- Bilateral x-rays for a unilateral condition; and
- X-rays in excess of two views.

> **Note:** The Department does not pay for radiology services with diagnosis code V72.5. Providers must bill the appropriate medical ICD-9-CM code.

Other Limitations

- PET Scans and MRI/MRAs are limited to one per day.
- Multiple CT Scans are allowed only if done at different times of the day or if modifiers LT or RT are attached.
- The Department does not pay radiologists for after-hours service codes.
- Claims must have the referring provider's national provider identifier (NPI) in the appropriate field on the claim form.

Contrast Material

Contrast material is not paid separately, except in the case of low-osmolar contrast media (LOCM) used in intrathecal, intravenous, and intra-arterial injections for clients with one or more of the following conditions:

- A history of previous adverse reaction to contrast material, with the exception of a sensation of heat, flushing, or a single episode of nausea or vomiting.
- A history of asthma or allergy.
- Significant cardiac dysfunction including recent or imminent cardiac decompensation, severe arrhythmia, unstable angina pectoris, recent myocardial infarction, and pulmonary hypertension.
- Generalized severe debilitation.
- Sickle cell disease.

To bill for LOCM, use the appropriate HCPCS procedure codes Q9945-Q9951. The brand name of the LOCM and the dosage must be documented in the client's record.

Radiopharmaceutical Diagnostic Imaging Agents

- When performing nuclear medicine procedures, separate payment is allowed for radiopharmaceutical diagnostic imaging agents (Q9945-Q9951).

- The Department allows the following CPT codes for radiopharmaceutical therapy without PA: CPT codes 79101, 79445, and 79005.

Ultrasound Screening for Abdominal Aortic Aneurysm
(HCPCS procedure code G0389)

The Department covers ultrasound screening for abdominal aortic aneurysm only when:

- Billed with diagnosis code V81.2 (special screening for other and unspecified cardiovascular conditions); and

- A client meets at least one of the following conditions:

  - ✓ Has a family history of an abdominal aortic aneurysm; or
  - ✓ Is a male who is between 65 and 75 years old and has smoked at least 100 cigarettes in his lifetime.

Outpatient PET Scans

The Department no longer offers Expedited Prior Authorization (EPA) for PET Scans. All covered PET Scans require written or faxed PA.

Mammograms

The Department has adopted the National Cancer Institute (NCI) recommendations regarding screening mammograms (CPT codes 77052, 77057, and G0202). For clients age 40 and over, one annual screening mammogram is allowed per calendar year. Screening mammograms for clients 39 years of age and younger requires PA.

Radiology Modifiers for Bilateral Procedures

- Bill the procedure on two separate lines using modifier 50 on one line only.
- Bill **modifier LT or RT** on separate lines when a radiological procedure is performed on the right and/or left side or extremity.
- Do not use modifier 50, LT, or RT if the procedure is defined as bilateral.

Anesthesia for Radiological Procedures **[Refer to WAC 388-531-0300 (2) and (7)]**

General anesthesia is allowed for radiological procedures for children and/or non-cooperative clients when the medically necessary procedure cannot be performed unless the client is anesthetized.

Providers **must** use the anesthesia CPT code 01922 when providing general anesthesia for non-invasive imaging or radiation therapy. **Do not** bill the radiological procedure code (e.g., CPT code 71010) with an anesthesia modifier to bill for the anesthesia procedure. When using CPT code 01922 for non-invasive imaging or radiation therapy:

- The client must be 17 years of age or younger; or
- A statement of the client-specific reasons why the procedure cannot be performed without anesthesia services must be kept in the client's medical record and made available to the Department on request.

Magnetic Resonance Imaging (MRI)

- Please check the fee schedule for authorization requirements for MRIs.
- The Department is implementing the Washington State Health Technology Clinical Committee (HTCC's) decision that uMRI (upright MRI) is **experimental and investigational;** therefore, pursuant to WAC 388-501-0165, uMRI is a "D" level evidence that is not supported by any evidence regarding its safety and efficacy. Medicaid will not reimburse unless one of the following criteria is met:

  ✓ The client must have a humanitarian device exemption; or
  ✓ There must be a local Institutional Review Board protocol in place.

Nuclear Medicine

When billing the Department for nuclear medicine, the multiple surgery rules are applied when the coding combinations listed below are billed:

- For the same client, on the same day, by the same physician or by more than one physician of the same specialty in the same group practice; or
- With other codes that are subject to the multiple surgery rules, not just when billed in the combinations specified below:
  - ✓ CPT code 78306 (bone imaging; whole body) and CPT code 78320 (bone imaging; SPECT);
  - ✓ CPT code 78802 (radionuclide localization of tumor; whole body), CPT code 78803 (tumor localization; SPECT), and CPT code 78804 (radiopharmaceutic localization of tumor requiring 2 or more days); or
  - ✓ CPT code 78806 (radionuclide localization of abscess; whole body) and 78807 (radionuclide localization of abscess; SPECT).

Consultation on X-Ray Examination

When billing a consultation, the consulting physician must bill the specific x-ray code with modifier 26 (professional component).

For example: The primary physician would bill with the global chest x-ray (CPT code 71020) or the professional component (CPT code 71020-26), and the consulting physician would bill only for the professional component of the chest x-ray (e.g., CPT code 71020-26).

Portable X-Rays

- Portable x-ray services furnished in a client's home or nursing facility and payable by the Department are limited to the following:

  ✓ Skeletal films involving extremities, pelvis, vertebral column, or skull;
  ✓ Chest or abdominal films that do not involve the use of contrast media; or
  ✓ Diagnostic mammograms.

- Bill for transportation of x-ray equipment as follows:

  ✓ R0070 - If there is only one patient bill one unit;

  ✓ R0075 - If there are multiple patients, **bill one unit** per individual client's claim with one of the following modifiers, as appropriate. ***You must bill using a separate claim form for each Department client seen.*** The Department pays the fee for procedure code R0075 divided by the number of clients, as outlined by the modifiers in the following table:

Procedure Code	Brief Description
R0070	Transport portable x-ray
R0075-UN	Transport port x-ray multipl-2 clients seen
R0075-UP	Transport port x-ray multipl-3 clients seen
R0075-UQ	Transport port x-ray multipl-4 clients seen
R0075-UR	Transport port x-ray multipl-5 clients seen
R0075-US	Transport port x-ray multipl-6 or more clients seen

Note: The Department's payment for procedure codes R0070 and R0075 includes setup. The fee for HCPCS code R0075 is divided among the clients served, as outlined by the modifiers indicated above. If no modifiers are used for HCPCS code R0075, the code will be denied. Do not bill HCPCS code R0070 in combination with HCPCS code R0075.

Heart Catheterizations

When a physician performs cardiac catheterization in a setting where the physician does not own the equipment (e.g., a hospital or ASC), the Department pays providers for the appropriate **procedure code with modifier 26 (professional component) only**.

Use cardiac catheterization and angiography to report services individually. It is not appropriate to bill with modifier 51 (multiple procedures) with any of these codes.

Pathology and Laboratory

[Refer to WAC 388-531-0800 and WAC 388-531-0850]

Certification

Independent laboratories must be certified according to Title XVII of the Social Security Act (Medicare) to receive payment from Medicaid. The Department pays laboratories for Medicare-approved tests only.

CLIA Certification

All reference (outside) labs and facilities performing laboratory testing must have a Clinical Laboratory Improvement Amendment (CLIA) certificate and identification number on file with the Department in order to receive payment from the Department.

To obtain a CLIA certificate and number, or to resolve questions concerning your CLIA certification, call 1-206-361-2805 or write to:

DOH - Office of Laboratory Quality Assurance
1610 NE 150th Street
Shoreline, WA 98155
1-206-361-2805 (phone); 1-206-361-2813 (fax)

Clinical Laboratory Codes

Some clinical laboratory codes have both a professional component and a technical component. If performing only the technical component, do not bill with a modifier. The professional component for physician interpretation must be billed using modifier 26. Laboratories performing both the professional and the technical components must bill the code without a modifier for the technical and with modifier 26 for the professional. These services may be billed either on separate lines or on separate claim forms. Refer to the table below for those codes with both a technical and professional component.

Laboratory Physician Interpretation Codes

The following codes are clinical laboratory codes for which separate payment for interpretations by laboratory physicians may be made. The actual performance of the tests is paid for under the laboratory fee schedule. Modifier TC must not be used with these codes. The total RVUs for laboratory physician interpretation codes include values for physician work, practice expense, and malpractice expense.

83020	84181	86255	86327	87207
83912	84182	86256	86334	88371
84165	85390	86320	86335	88372
84166	85576	86325	87164	89060

Laboratory Codes Requiring Modifier and PA Clarification

Laboratory claims must include an appropriate medical diagnosis code, modifier, and PA, if applicable. The ordering provider must give the appropriate medical diagnosis code, modifier, and PA number, if applicable, to the performing laboratory at the time the tests are ordered. The Department does not pay for laboratory procedures billed using ICD-9-CM diagnosis codes V72.6, V72.62, V72.63, or V72.69. For lab services, use the appropriate diagnosis for the service(s) that was provided.

Cancer Screens (HCPCS codes G0101, G0103-G0105, 82270)

The Department covers the following cancer screenings:

- Cervical or vaginal;
- Prostate;
- Colorectal;
- Pelvic/breast exams;
- Screening sigmoidoscopies;
- Colonoscopies; and
- PSA testing.

HCPCS Code	Brief Description	Limitations	Payable Only With Diagnosis Code(s)
G0101	CA screen; pelvic/breast exam	Females only One every 12 months *[Use for Pap smear professional services]*	V25.40-V25.49, V72.31, V76.2, or V76.47
G0103	PSA screening	Once every 12 months when ordered	Any valid ICD-9-CM code other than high risk (e.g., V76.44)
G0104	CA screen; flexi sigmoidscope	Clients age 50 and older who are not at high risk Once every 48 months	Any valid ICD-9-CM code other than high risk (e.g., V76.51)
G0105*	Colorectal scrn; hi risk ind	Clients at high risk for colorectal cancer One every 24 months	High risk 555.1, 555.0, 555.2, 555.9, 556.0-556.6, 556.8, 556.9, 558.2, 558.9, V10.05, V10.06, V12.72, V84.09, V16.0, or V18.51
82270	Occult blood, feces	N/A	Any valid ICD-9-CM code (e.g., V76.51)
G0121*	Colon CA scrn; not high risk ind	Clients age 50 and older Once every 10 years	Any valid ICD-9-CM code other than high risk (e.g., V76.51)
G0122	Colon CA scrn; barium enema	Clients age 50 and older Once every 5 years	Any valid ICD-9-CM code other than high risk (e.g., V76.51)

***Note**: Per Medicare guidelines, the Department's payment is reduced when billed with modifier 53 (discontinued procedure).

Coding and Payment Policies

- Pathology and laboratory services must be provided either by a pathologist or by technologists who are under the supervision of a physician.
- Physicians must bill using their NPI for laboratory services provided by their technicians under their supervision.
- An independent laboratory and/or hospital laboratory must bill using its NPI for any services performed in its facility.
- The Department pays for one blood draw fee (CPT codes 36415-36416 or 36591) per day.
- The Department pays for one catheterization for collection of a urine specimen (HCPCS code P9612) per day.
- Complete blood count (CPT code 85025) includes the following CPT codes: 85004, 85007, 85008, 85009, 85013, 85014, 85018, 85027, 85032, 85041, 85048, 85049, and G0306. Complete blood count (CPT code 85027) includes the following CPT codes: 85004, 85008, 85013, 85014, 85018, 85032, 85041, 85048, 85049, and G0307.
- CPT codes 81001-81003 and 81015 are not allowed in combination with urinalysis procedure 81000.
- CPT codes 86812-86822 are limited to a maximum of 15 tests total for human leukocyte antigens (HLA) typing per client, per lifetime. Prior authorization is required for more than 15 tests.
- Do not bill with modifier 26 if the description in CPT indicates professional services only.
- Payment for lab tests includes handling, packaging and mailing fee. Separate payment is not allowed.
- Laboratories must obtain PA from the ordering physician or Department-approved genetic counselor to be paid for certain genetic testing that requires PA. All genetic testing must be billed with the appropriate genetic testing modifier.
- CPT code 83037 [hemoglobin glycosylated (A1C)] no longer requires PA when performed in a physician's office; however, it can be billed only once every three months.

Note: Laboratory claims must include an appropriate medical diagnosis code and PA if applicable. The ordering provider must give the appropriate medical diagnosis code, prior authorization number, and modifier, if applicable, to the performing laboratory at the time the tests are ordered. **The Department does not pay a laboratory for procedures billed using ICD-9-CM diagnosis codes V72.6, V72.62, V72.63, or V72.69 as a primary diagnosis. For lab services use the appropriate diagnosis for the service(s) that was provided.**

- CPT code 87999 can be used for billing the monogram Trofile test for AIDS patients when physicians are prescribing the drug Selzentry®. CPT code 87999 is paid By Report.

Drug Screens

- The Department pays for drug screens only when:
  - ✓ Medically necessary and ordered by a physician as part of a medical evaluation; and
  - ✓ The drug and/or alcohol screens are required to assess suitability for medical tests or treatment being provided by the physician.
  - ✓ The provider is certified and approved to prescribe Buprenorphine-Suboxone (see # Memo 03-58 MAA). The provider must have a CLIA waiver. Enter the following information on the CMS-1500 Claim Form:
    - ➢ ICD-9-CM diagnosis codes 304.01-304.03;
    - ➢ CPT codes 80101, 80102, or 80103 QW are covered only for ICD-9-CM diagnoses 304.01-304.03. The maximum combined total allowable is 2 units per day; and
    - ➢ "Certified bupren provider" in field 19.
- The Department does not pay for drug screens to **monitor** any of the following:
  - ✓ Program compliance in either a residential or outpatient drug or alcohol treatment program;
  - ✓ Drug or alcohol use by a client when the screen is performed by a provider in a private practice; or
  - ✓ Suspected drug use by clients living in a residential setting such as a group home.

  When clients need to be monitored for drug/alcohol use, please refer them to a DASA-approved program for evaluation/treatment.
- For clients in the Division of Alcohol and Substance Abuse (DASA) contracted methadone treatment programs and pregnant women in DASA-contracted treatment programs, drug screens are paid through a contract issued to one specific laboratory by DASA, not through the Department.

Laboratory Services Referred by Community Mental Health Center (CMHC) or DASA-Contracted Providers

When CMHC or DASA-contracted providers refer clients enrolled in a Department managed care plan for laboratory services, the laboratory **must bill the Department directly.** The following conditions apply:

- The laboratory service is medically necessary;
- The laboratory service is **directly** related to the client's mental health or alcohol and substance abuse;
- The laboratory service is referred by a CMHC or DASA-contracted provider who has a core provider agreement with the Department;
- The laboratory must bill with a mental health, substance abuse, or alcohol abuse diagnosis; and
- The screen must meet the criteria above in "Drug Screens."

To bill for laboratory services, laboratories **must** put the seven-digit CMHC or DASA-contracted referring provider identification number assigned by the Department in the "referring provider" field of the claim form. CMHC and DASA-contracted services are excluded from the Department's managed care contracts.

Disease Organ Panels--Automated Multi-Channel Tests

The Department pays for CPT lab panel codes 80047, 80048, 80050, 80051, 80053, 80061, 80069, and 80076. The individual automated multi-channel tests are:

Procedure Code	Brief Description
82040	Albumin; serum
82247	Bilirubin; total
82248	Bilirubin; direct
82310	Calcium; total
82330	Calcium, ionized
82374	Carbon dioxide (bicarbonate)
82435	Chloride; blood
82465	Cholesterol, serum, total
82550	Creatine kinase (CK)
82565	Creatine; blood
82947	Glucose; quantitative
82977	Glutamyltransferase, gamma (GGT)
83615	Lactate dehydrogenase (LD) (LDH)
84075	Phosphatase, alkaline
84100	Phosphorous inorganic (phosphate)
84132	Potassium; serum
84155	Protein; total, except refractometry
84295	Sodium; serum
84450	Transferase; apartate amino (AST)(SGOT)
84460	Transferase; alanine amino (AST)(SGPT)
84478	Tryglycerides
84520	Urea nitrogen; quantitative
84550	Uric acid; blood
85004	Automated diff wbc count
85007	B1 smear w/diff wbc count
85009	Manual diff wbc count b-coat
85027	Complete cbc, automated

- Providers may bill a combination of panels and individual tests not included in the panel. Duplicate tests will be denied. Providers may not bill for the tests in the panel separately per the National Correct Coding Initiative.

- Each test and/or panel must be billed on a separate line.

- All automated/non-automated test***s must be billed on the same claim form when performed for a client by the same provider*** on the same day. For laboratory services that exceed the lines allowed per claim, see next page.

Billing for laboratory services that exceed the lines allowed

- Providers who bill on hardcopy CMS-1500 Claim Forms are allowed up to 6 lines per claim. Direct entry, magnetic tape, or electronic submitters are allowed 50 lines per claim. **Use additional claim forms if the services exceed the lines allowed**. Enter the statement: "Additional services" in field 19 when billing on a hardcopy CMS-1500 Claim Form or in the *Comments* section when billing electronically. Total each claim separately.

- If the Department pays a claim with one or more automated/non-automated lab tests, providers must bill any additional automated/non-automated lab tests for the same date of service on an Adjustment Request form, DSHS# 525-109. Refer to the Important Contacts section for ordering/downloading Department forms. Make sure you adjust the claim with the paid automated/non-automated lab tests using the comment "**additional services.**"

Payment for Automated Multi-Channel Tests

For individual automated multi-channel tests, providers are paid on the basis of the total number of individual automated multi-channel tests performed for the same client, on the same day, by the same laboratory.

- When all the tests in a panel are not performed, each test must be billed as a separate line item on the claim form.
- When there are additional automated multi-channel tests not included in a panel, each additional test must be billed as a separate line item on the claim form.
- Bill any other individual tests as a separate line item on the claim form.

Payment calculation for individual automated laboratory tests is based on the total number of automated multichannel tests performed per day, per patient. Payment for each test is based on Medicare's fees multiplied by the Department's fiscal year laboratory conversion factor.

For example:

- If five individual automated tests are billed, the payment is equal to the internal code's maximum allowable fee.
- If five individual automated tests ***and*** a panel are billed, the Department pays providers separately for the panel at the panel's maximum allowable. Payment for the individual automated tests, less any duplicates, is equal to the internal code's maximum allowable fee.

If one automated multi-channel test is billed, payment is at the individual procedure code or internal code's maximum allowable fee, whichever is lower. The same applies if the same automated multi-channel test is performed with modifier 91 (see page E.24 for information on modifier 91).

Disease Organ Panel--Non-automated Multi-Channel

Organ and disease panels (CPT codes 80055 and 80074) do not include automated multi-channel tests. If all individual tests in the panel are not performed, payment is the individual procedure code maximum allowable fee or billed charge, whichever is lower.

The non-automated multi-channel tests are:

CPT Code	Brief Description
83718	Assay of lipoprotein
84443	Assay thyroid stim hormone
85025	Automated hemogram
85651	Rbc sed rate, nonautomated
86255	Fluorescent antibody, screen
86430	Rheumatoid factor test
86592	Blood serology, qualitative
86644	CMV antibody
86694	Herpes simplex test
86705	Hep b core antibody, test
86709	Hep a antibody, igm
86762	Rubella antibody
86777	Toxoplasma antibody
86803	Hep c ab test, confirm
86850	RBC antibody screen
86900	Blood typing, ABO
86901	Blood typing, Rh(D)
87340	Hepatitis b surface ag, eia

Laboratory Modifiers

Modifier QP

Modifier QP indicates documentation is on file showing that the lab test(s) was ordered individually or ordered as a CPT®-recognized panel. The Department recognizes this modifier as ***informational only***. **This modifier is *not* appropriate to use for billing repeat tests or to indicate the test was not done as a panel.**

Modifier 90

Reference (Outside) Laboratory: When a laboratory sends a specimen to a reference (outside) laboratory, the referring laboratory may bill for the reference laboratory (pass-through billing) by adding modifier 90 to the laboratory procedure code. *The reference laboratory NPI must be entered in the performing number field on the claim form.*

Modifier 91

Repeat Clinical Laboratory Diagnostic Test

When it is necessary to repeat the same lab test on the same day for the same client to obtain subsequent (multiple) test results, use modifier 91. Otherwise, the claim will be denied as a duplicate.

Do not use this modifier when tests are rerun:

- To confirm initial results;
- Due to testing problems with specimens or equipment;
- For any reason when a normal, one-time, reportable result is all that is required; or
- When there are standard procedure codes available that describe the series of results (e.g., glucose tolerance test, evocative/suppression testing, etc.).

Pap Smears

For professional services related to Pap smears, refer to the Cancer Screens Section (page E.13).

- Use CPT codes 88147-88154, 88164-88167, and P3000-P3001 for conventional Pap smears.

- The Department pays for thin layer preparation CPT codes 88142-88143 and 88174-88175. The Department does not pay providers for HCPCS codes G0123-G0124 and G0141-G0148. The Department pays for thin layer Paps at Medicare's payment levels. Thin layer preparation and conventional preparation CPT codes cannot be billed in combination.

- Use CPT codes 88141 and 88155 in conjunction with codes 88142-88143 and 88164-88167.

- Use the appropriate medical diagnosis if a condition is found.

- The Department pays providers for one routine Pap smear per client, per calendar year only. The Department considers routine Pap smears to be those billed with an ICD-9-CM diagnosis of V76.2, V72.31, V76.47, or V25.40-V25.49. For clients on the TAKE CHARGE or Family Planning Only programs, use diagnosis codes from the V25 series diagnosis codes, excluding V25.3.

- The Department does not pay providers for CPT code 88112 with diagnosis V72.3 or V76.2.

HIV Testing

The Department pays providers for HIV testing (CPT codes 86701-86703) for ICD-9-CM diagnosis codes 042, 079.53, V01.79, V08, V22.0, V22.1, V22.2 or V28.89 only.

Blood Bank Services

The following blood bank HCPCS codes are now reimbursed at Acquisition Cost (AC).

Procedure Code	Brief Description
J7185	Xyntha, inj.
J7186	Antihemophilic viii/vwf comp
J7187	Inj Vonwillebrand factor IU
J7189	Factor VIIa
J7190	Factor VIII
J7191	Factor VIII (porcine)
J7192	Factor VIII recombinant
J7193	Factor IX non-recombinant
J7194	Factor IX complex
J7195	Factor IX recombinant
J7197	Antithrombin III injection
J7198	Anti-inhibitor

STAT Lab Charges

When the laboratory tests listed on the following page are performed on a STAT basis, the provider may bill **HCPCS code S3600** (Stat laboratory request).

- Payment is limited to one STAT charge per episode (not once per test).
- Tests must be ordered STAT and payment is limited to only those that are needed to manage the client in a true emergency.
- The laboratory report must contain the name of the provider who requested the STAT.
- The medical record must reflect the medical necessity and urgency of the service.

Note: "STAT" must be clearly indicated by the provider and must be documented in the laboratory report and the client's record. Tests generated from the emergency room do not automatically justify a STAT order. Use **HCPCS code S3600** with the procedure codes on the following page.

The STAT charge is paid only with the tests listed below:

Procedure Code	Brief Description
G0306	CBC/diffwbc w/o platelet
G0307	CBC without platelet
80047	Metabolic panel ionized ca
80048	Basic metabolic panel
80051	Electrolyte panel
80069	Renal function panel
80076	Hepatic function panel
80100	Drug screen, qualitate/multi
80101	Drug screen, single
80156	Assay, carbamazepine, total
80162	Assay of digoxin
80164	Assay, dipropylacetic acid
80170	Assay of gentamicin
80178	Assay of lithium
80184	Assay of phenobarbital
80185	Assay of phenytoin, total
80188	Assay primidone
80192	Assay of procainamide
80194	Assay of procainamide
80196	Assay of salicylate
80197	Assay of tacrolimus
80198	Assay of theophylline
81000	Urinalysis, nonauto w/scope
81001	Urinalysis, auto w/scope
81002	Urinalysis, nonauto w/o scope
81003	Urinalysis, auto, w/o scope
81005	Urnalysis
82003	Assay of acetaminophen
82009	Test for acetone/ketones
82040	Assay of serum albumin
82055	Assay of ethanol
82150	Assay of amylase
82247	Bilirubin; total
82248	Bilirubin; direct
82310	Assay of calcium
82330	Assay of calcium
82374	Assay, blood carbon dioxide
82435	Assay of blood chloride
82550	Assay of ck (cpk)
82565	Assay of creatinine
82803	Blood gases: pH, pO2 & pCO2
82945	Glucose other fluid
82947	Assay, glucose, blood quant

Procedure Code	Brief Description
83615	Lactate (LD) (LDH) enzyme
83663	Test urine for lactose
83664	Lamellar bdy, fetal lung
83735	Assay of magnesium
83874	Assay of myoglobin
83880	Natriuretic peptide
84100	Assay of phosphorus
84132	Assay of serum potassium
84155	Assay of protein
84157	Assay of protein, other
84295	Assay of serum sodium
84302	Assay of sweat sodium
84450	Transferase (AST)(SGOT)
84484	Assay of troponin, quant
84512	Troponin qualitative
84520	Assay of urea nitrogen
84550	Assay of blood/uric acid
84702	Chorionic gonadotropin test
84704	Hcg, free betachain test
85004	Automated diff wbc count
85007	Differential WBC count
85025	Complete cbc w/auto diff wbc
85027	Automated hemogram
85032	Manual cell count, each
85046	Automated hemogram
85049	Automated platelet count
85378	Fibrin degradation
85380	Fibrin degradation, vte
85384	Fibrinogen
85396	Clotting assay, whole blood
85610	Prothrombin time
85730	Thromboplastin time, partial
86308	Heterophile antibodies
86367	Stem cells, total count
86403	Particle agglutination test
86880	Coombs test
86900	Blood typing, ABO
86901	Blood typing, Rh (D)
86920	Compatibility test
86921	Compatibility test
86922	Compatibility test
86923	Compatibility test, electric
86971	RBC pretreatment
87205	Smear gram stain
87210	Smear, wet mount, saline/ink

Procedure Code	Brief Description
87281	Pneumocystis carinii, ag, if
87327	Cryptococcus neoform ag, eia
87400	Influenza a/b, ag, eia
89051	Body fluid cell count
86367	Stem cells, total count
86923	Compatibility test, electric
88720	Bilirubin, total, transcutaneous
88740	Transcutaneous carboxyhb
88741	Transcutaneous methb